

Accident / Incident Report Closed



Unit/Department	Process Area	Site	Report Number			
South Operation-Elyria	General Catalyst – Building 9	ELYRIA	0084-SOPS-15-0057			
Report Date	Incident Date	Incident Time	Copied From			
05/06/2015	05/05/2015	09:00 PM				
Incident Location	Team Leader / Supervisor	Reported By				
Building #9 at the PK Blender discharge station	Brian Beller	non-responsive				
Title of Event (Limit to 90 characters)	Category	Division / Bus. Group / Subgroup Code				
Operator was exposed to chrome/aluminum dust while unloading the PK Blender	<input type="checkbox"/> Safety & Health <input type="checkbox"/> Environmental	CC / G-CCP				
Incident Classification						
<input type="checkbox"/> Near Miss <input type="checkbox"/> Property Loss <input type="checkbox"/> Contractor <input type="checkbox"/> Process Safety <input type="checkbox"/> Citation / NOV <input type="checkbox"/> Contractor Injury / Illness <input type="checkbox"/> Injury / Illness <input checked="" type="checkbox"/> Health Exposure <input type="checkbox"/> Contract Injury / Illness <input type="checkbox"/> Spill / Release <input type="checkbox"/> Inspection <input type="checkbox"/> PSM <input type="checkbox"/> Permit / Regulatory Deviation <input type="checkbox"/> Major Incident <input type="checkbox"/> Plant Upset <input type="checkbox"/> Fire <input type="checkbox"/> Non-Occupational <input type="checkbox"/> EHS Management System Failure <input type="checkbox"/> Odor Complaint <input type="checkbox"/> RMP <input type="checkbox"/> Other						
Describe Event / What Happened						
<p>While operating the PK blender in Building #9, the operator was discharging the blender into a sack and was exposed to Oxyvinyls Catoxid 5 impregnation. He was attempting to lift up the neck of the bag in order to clear out a powder build up in the discharge chute, and had the clamp for the neck off. When he let go of the neck a puff of material came out of the bag coating his PAPR and the exposed side of his face as well as the upper part of his Tyvek suit. He called his floor CRT to come and take a look and then vacuumed off and showered. Later in the night the operator noticed that the areas of his neck that had been exposed broke out in a rash which went away overnight.</p>						
Immediate Corrective Action or Response						
Reattached the bag neck and cleaned up exposed skin and PAPR.						
Immediate Cause						
Accidental overfilling of Sack caused unnecessary exposure						
Cause Narrative						
Operator overfilled the bag that he was unloading into due to discharge valve not fully closing.						
Contributing Causes		Root/Primary Causes				
Discharge valve did not close properly causing material to leak from the blender.		138 - Human Factors Engineering 160 - Intolerant System 161 - Errors Not Detectable				
Operator exposed himself to chemicals by removing an exposure safety system, because of an accidental over filling of his bag.		163 - Training 170 - Training LTA 179 - Abnormal Events/Emergency Training LTA				
Any known or potential off-site impacts?	No	PSM Incident?	No			
Investigation Team	William Grodecki; John E Peshek; John Bodmann; Andrea Bal; Brian Beller					
Item	Corrective Action(s) to prevent recurrence	Responsible Person	Target Date	Final Closed Date	VC Req	VE Req
1	Replace discharge valve of PK blender.	John Bodmann/BASF-CATALYSTS/BASF	09/30/2015	09/28/2015	N	N
2	Review process safety for abnormal process events and emergencies in upcoming safety meeting.	John E Peshek/NA/BASF	09/30/2015	09/25/2015	N	N

3	Determine a better way to unload bag to prevent overfill	Robert Orig/BASF-CATALYSTS/BASF	09/23/2015	06/30/2015	N	N
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Approved By:		
Manager / Dept. Head	Leon Zavodnik	05/23/2015 01:52 AM
EHS Unit Coordinator	Valerie Topete	05/22/2015 11:29 AM
Confidential		















